

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06482

CERTIFICATE OF DEATH

06469

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Denton		c. LENGTH OF STAY IN b 40 Yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Garfield		First Garfield	Middle Bilbrough
4. DATE OF DEATH 12-23-1883		Month 5	Doy 28
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. B. DATE OF BIRTH 12-23-1883		9. AGE (In years last birthday) 83 yrs.	10. IF UNDER 1 YEAR Months 0 Doy 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farming	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Samuel Bilbrough		14. MOTHER'S MAIDEN NAME Katherine Alwine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-44-6656	17. INFORMANT Mary Faithful Greensboro, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		Coronary Occlusion	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Arteriosclerotic C.V.Disease		DUE TO (b) Arteriosclerotic C.V.Disease	
DUE TO (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) 		(County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from June 5, 1966 to May 28, 1967 , that (I) (we) last saw the deceased alive on May 28, 1967 , and that death occurred at M , from causes and on the date stated above			
22a. SIGNATURE Charles H. Stonesifer		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED May 30 '67
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md. 21639	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-31-67	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Greensboro
24. FUNERAL DIRECTOR J. E. Boulaire		25a. LOCATION (City or Town) Greensboro, Md.	(County) (State)
		25b. REC'D BY REGISTRAR JUN 2 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE
HEALTH DEPT. M

06483

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06470

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours of death.

f. PLACE OF DEATH a. COUNTY		Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN fb 6 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton,		d. STREET ADDRESS None		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Christopher Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
Edith Mae Henry Colbern					May	7	19	67
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED DIVORCED	B. DATE OF BIRTH 9-18-1914	9. AGE (In years last birthday) 52	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Arthur Anthony		14. MOTHER'S MAIDEN NAME Rella Smith				Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-09-7792		17. INFORMANT Albert N. Henry Denton, Maryland		18. INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation chronic with</u> <u>4344</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>left ventricular Dilatation & hypertrophy</u> DUE TO (c) <u>Generalized arteriosclerosis</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Hyperthyroidism</u>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>Harold B. Plummer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)						
EXAMINER'S NAME (Type) Harold B. Plummer		22. DATE SIGNED 5/8/67						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-10-67		23c. NAME OF CEMETERY OR CREMATORIAL Denton		23d. LOCATION (City or Town) (County) (State) Denton, Maryland		
24. FUNERAL DIRECTOR J. S. Boulaire, Greensboro, Md.		ADDRESS		25a. REC'D BY REGISTRAR DATE MAY 10 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

CERTIFICATE OF DEATH				05471					
1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HILLSBORO				c. LENGTH OF STAY IN lb 85					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS					
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) WILLIAM ALBERT COLLINS				First	Middle	Last	4. DATE OF DEATH MAY 27 1967		
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		8. DATE OF BIRTH JULY 7, 1903			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
13. FATHER'S NAME GEORGE T. COLLINS				14. MOTHER'S MAIDEN NAME NETTIE WARNER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. (d. Albert Collins HILLSBORO Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastases to cerebral cortex DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 163x (b) Cancerous of the lung DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH 1963					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
MEDICAL CERTIFICATION		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
		20c. TIME OF INJURY Hour a.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) None (County) None (State) None	
21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to May 30, 1967 , that (I) (we) last saw the deceased alive on May 30, 1967 , and that death occurred on May 27, 1967 at 6 a.m. from causes and on the date stated above.									
22a. SIGNATURE KURT LEDERER		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED May 29, 1967			
22c. PHYSICIAN'S NAME (Type) KURT LEDERER		22d. ADDRESS QUEEN ANNE MD.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 30, 1967		23c. NAME OF CEMETERY OR CREMATORIAL GREENMOUNT		23d. LOCATION (City or Town) HILLSBORO MD. (County) None (State) None			
24. FUNERAL DIRECTOR Charles Wood Denton Jr.		ADDRESS		25a. REC'D BY REGISTRAR JUN 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 20 M 1/66				DATE					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

06472

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. <u>MARYLAND</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>		b. COUNTY <u>CAROLINE</u>	
c. LENGTH OF STAY IN 1b <u>life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL DENTON</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00</u>		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <u>SAMUEL</u>	Middle <u>TAYLOR</u>
4. DATE OF DEATH		Month <u>MAY</u>	Day <u>8</u>
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>NOV 12, 1893</u>		9. AGE (In years last birthday) <u>73 yrs.</u>	10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PHOTOGRAPHER</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>W.M. HENRY JOPP</u>	14. MOTHER'S MAIDEN NAME <u>MARY ELLEN TAYLOR</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs. Florence Jopp Denton</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emphysema</u>		Address	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Fibrosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <u>Generalized Arteriosclerosis</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <u>Greensboro</u> (County) <u>MD</u> (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 28, 1967</u> to <u>May 8, 1967</u> that (I) (we) last saw the deceased alive on <u>May 8, 1967</u> , and that death occurred at <u>M</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles H. Stonesifer</u>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Stonesifer, M.D.</u>		22d. ADDRESS <u>Greensboro, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>May 10, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL <u>DENTON</u>
24. FUNERAL DIRECTOR <u>J. D. R. G. D. MOORE</u>		ADDRESS <u>DENTON</u>	25a. RECORDARY REGISTRAR <u>MAY 15 1967</u>
			25b. REGISTRAR'S SIGNATURE <u>Charles J. Moore</u>

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Caroline MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro c. LENGTH OF STAY IN lb 1 week		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ridgely d. STREET ADDRESS None	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ethel Elizabeth Quimby First Ethel Middle Elizabeth Last Quimby		4. DATE OF DEATH Month May Day 20 Year 1967	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1902 9. AGE (in years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME Daisey Tribbitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-34-9248D 17. INFORMANT Breeding Address Md. Mrs. Mary Breensing Greensboro	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) DETO last.		Coronary Thrombosis Arteriosclerotic C.V.Dis. with Hypertension	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 10, 1966 to May 20, 1967 , that (I) (we) last saw the deceased alive on May 19, 1967 , and that death occurred at M , from causes and on the date stated above.		22b. DATE SIGNED May 22 '67	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.		22d. ADDRESS Greensboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-23-67	
23c. NAME OF CEMETERY OR CREMATORIAL Holy Cross		23d. LOCATION (City or Town) (County) (State) Greensboro, Md.	
24. FUNERAL DIRECTOR J. E. Boulaire		25a. REC'D BY REGISTRAR MAY 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

06487

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician and the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY		Caroline MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Greensboro		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Goldsboro	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS None	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)		First Annette	Middle	Last Snively	4. DATE OF DEATH 5 9 1967
5. SEX		6. COLOR OR RACE Female Col	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 19, 1966	9. AGE (in years last birthday) 10 yrs. 10 months 20 days 20 hours 0 min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Annette Snively	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Caroline Co. Welfare Denton, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (b) Chronic Bronchiolitis		Occlusion of the bronchus and atelectasis caused by aspiration of mucus	
		DUE TO (c) Chronic Bronchial Asthma			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Brain damage due to Neonatal anoxia, probable hydrocephalus				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office/bldg., etc.)	20f. (City or town) Greensboro, Md.	(County) Greensboro, Md.
20f. (City or town) Greensboro, Md.				(State)	
21. I certify that (I) (this hospital) attended the deceased from July 23, 1966, to May 9, 1967, that (I) (we) last saw the deceased alive on May 9, 1967, and that death occurred at M, from the causes and on the date stated above.				22b. DATE SIGNED May 9, 1967	
22a. SIGNATURE Charles H. Stonesifer		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS Greensboro, Md.	
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-11-67	23c. NAME OF CEMETERY OR CREMATORIAL Cokers	23d. LOCATION (City, town or county) Greensboro, Md.	
24. FUNERAL DIRECTOR J. E. Boulaire		ADDRESS Greensboro, Md.		25a. REC'D BY REGISTRAR MAY 15 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06488

CERTIFICATE OF DEATH

06475

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HILLSBORO</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>				
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL HILLSBORO</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <u>ADELIN</u>	Middle <u>THOMAS</u>	Last <u>STANTON</u>			
4. DATE OF DEATH Month <u>M</u> Day <u>12</u> Year <u>1967</u>	Month <u>May</u> Day <u>6</u> Year <u>1967</u>	Month <u>May</u> Day <u>6</u> Year <u>1967</u>	Month <u>May</u> Day <u>6</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 6, 1892</u>			
9. AGE (In years at last birthday) <u>75</u> yrs.	10. KIND OF BUSINESS OR INDUSTRY <u>At home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>WILLIAM E. THOMAS</u>	14. MOTHER'S MAIDEN NAME <u>AMELIA T. N DCHOLS</u>	Address <u>Mrs Georgia Tuxon, 17 Hillbush Rd</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	16. SOCIAL SECURITY NO.	17. INFORMANT <u>Mrs Georgia Tuxon, 17 Hillbush Rd</u>	18. INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>151X</u> DUE TO <u>Acute static carcinoma of the liver</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Aden carcinoma of the stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>				
DUE TO <u>Aden carcinoma of the stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>				
DUE TO <u>Aden carcinoma of the stomach</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>6 Sept 1967</u>	20f. (City or town) <u>Hillsboro</u>	(County) <u>Caroline</u>	(State) <u>MD</u>
21. I certify that (I) (this hospital) attended the deceased from <u>6 Sept 1967</u> to <u>10 Sept 1967</u> that (I) (we) last saw the deceased alive on <u>Aug 6, 1967</u> , and that death occurred at <u>10 p.m.</u> , from causes and on the date stated above.						
22a. SIGNATURE <u>Kurt Lederer</u>		M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>May 9, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>KURT LEDERER</u>		22d. ADDRESS <u>QUEEN ANNE MD</u>				
23a. BURIAL, CREMATION REMOVAL <input type="checkbox"/>		23b. DATE THEREOF <u>May 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <u>SAND TOWN</u>	23d. LOCATION (City or Town) <u>HILLSBORO MD</u> (County) <u>Caroline</u> (State) <u>MD</u>		
24a. FUNERAL DIRECTOR NAME <u>J. STRGEL MOORE LENTON</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

06489

06476

1. PLACE OF DEATH a. COUNTY Caroline		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural		c. LENGTH OF STAY IN 1b 40 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bridgeville Road				d. STREET ADDRESS Bridgeville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First CLARENCE	Middle GARRISON	Last TAYLOR	4. DATE OF DEATH	Month May	Day 27	Year 1967
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1904	9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman at Maryland Plastics, Inc.		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Sussex County, Del.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Hugh G. Taylor		14. MOTHER'S MAIDEN NAME Jennie Smith					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-03-9667		17. INFORMANT Mrs. Virgie Taylor, Federalsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201		acute myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 12 hrs	
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO DUE TO DUE TO					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-27-67, 19, to 5-27-67, 19, that (I) (we) last saw the deceased alive on 5-27-67, and that death occurred at 4:45 M, from the causes and on the date stated above.							
22a. SIGNATURE Frank M. Anderson		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED May 29, 1967
22c. PHYSICIAN'S NAME (Type) Frank M. Anderson, M.D.		22d. ADDRESS Federalsburg, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 29, 1967		23c. NAME OF CEMETERY OR CREMATORIAL Hill Crest Cemetery		23d. LOCATION (City, town or county) (State) Federalsburg, Maryland	
24. FUNERAL DIRECTOR J. J. Frampston Jr.		ADDRESS J. J. Frampston and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR DATE JUN 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												
CERTIFICATE OF DEATH												
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Federalburg - Rural				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalburg - Rural								
c. LENGTH OF STAY IN 1b 75 years												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bridgeville Road				d. STREET ADDRESS Bridgeville Road								
3. NAME OF DECEASED (Type or print)		First JANE	Middle TODD	Last WHITE	4. DATE OF DEATH May 16 1967	Month May	Day 16	Year 1967	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1874	9. AGE (In years last birthday 93 yrs.)	10. IF UNDERR 1 YEAR Months	11. IF UNDERR 24 HRS. Odays	12. IF UNDERR 24 HRS. Hours	13. CITIZEN OF WHAT COUNTRY? USA			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework			10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (County & State, or foreign country) Ridgeway, North Carolina								
13. FATHER'S NAME Edward Henry Bowman				14. MOTHER'S MAIDEN NAME Phoebe Elizabeth Burns								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. -----		17. INFORMANT Mrs. Mary E. Handy, Seaford, Del., RFD		Address						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X OUE TO Cardiac Failure Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinomatosis OUE TO (c) Carcinoma - breast												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Congestive heart failure												
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Federalsburg		(County) Maryland	(State) Maryland	
21. I certify that (I) (this hospital) attended the deceased from March 11, 1960, to March 8, 1967, that (I) (we) last saw the deceased alive on March 8, 1967, and that death occurred at M, from the causes and on the date stated above.												
22a. SIGNATURE <i>H. R. Trapnell</i> 22b. DATE SIGNED May 17, 1967												
22c. PHYSICIAN'S NAME (Type) H. R. Trapnell, M.D.				22d. ADDRESS Federalsburg, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 19, 1967		23c. NAME OF CEMETERY OR CEMINATORY Hill Crest Cemetery		23d. LOCATION (City, town or county) Federalsburg, Maryland				(State) Maryland
24. FUNERAL DIRECTOR <i>J. J. Trapnell & Son</i>				25a. REC'D BY REGISTRAR JUN 1 1967								25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1920-21 - 1921-22

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			Caroline MARYLAND			a. STATE			Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Federalsburg			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			Federalsburg 05-1		
c. LENGTH OF STAY IN 1b			6 years			d. STREET ADDRESS			411 Railroad Avenue		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
411 Railroad Avenue		411 Railroad Avenue									
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year			
BERTHA EDNA WILLIAMSON		BERTHA	EDNA	WILLIAMSON	May	11	1967				
5. SEX		6. COLOR DR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS				
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 21, 1902	64 yrs.	Months	Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
Housework			Home			Caroline Co., Maryland			USA		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Edward Sharp						Ebbie Dean					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		219-05-8828		W. Lacey Williamson, Federalsburg, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Cervix with 191X</u>											
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b) <u>generalized metastasis</u>		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>14 months</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from <u>May 11, 1967</u> to <u>May 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>May 11, 1967</u> , and that death occurred at <u>5:55 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Frank M. Anderson</u>											
22b. DATE SIGNED <u>May 12, 1967</u>											
22c. PHYSICIAN'S NAME (Type)		Frank M. Anderson, M.D.		22d. ADDRESS		Federalsburg, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)					
Burial		May 14, 1967		Hill Crest Cemetery		Federalsburg, Maryland					
24. FUNERAL DIRECTOR ADDRESS											
J. J. Frampton & Son, Federalsburg, Maryland											
25a. REC'D BY REGISTRAR DATE MAY 18 1967 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											

